Lions Sight Foundation of Clark County
P.O. Box 1804
Vancouver, WA 98668-1804

This committee meets the first Tuesday of each month.

Applicants must complete **ALL** sections of this **TWO PAGE** application to be eligible for services. Incomplete applications could result in delay or denial of service.

PRINT

Last Name First Name Middle Initial		Date of Birth Age
Parent or Guardian Name(s) (if applicant is under 18 years of age)		Applicants Social Security #
Address City State Zip		Driver License Number & State
Home Phone	Work Phone	Cell Phone
List previous address(s), if less than one year at the above address. (Attach additional sheets as needed)		
List ALL household members - show relationship and ages of each. (Attach additional sheets as needed)		
Are you a citizen of the United States? (circle one) Yes / No **If NO**, Are you a Registered United States Permanent Resident? (circle one) Yes / No **Enter INS or A #:**		Do you live in Clark County? (circle one) Yes / No How long have you lived in Clark County? Yrs_____
Occupation	Employer and Address	Work Phone Number
Is applicant a student?	List name of school attending	Grade or Year
List names of all other students in the household on free or reduced lunch programs		
Does applicant have Vision Insurance coverage? (Circle one) NO VISION INSURANCE / YES If YES List Provider _____		
Circle your appropriate Medical coverage: Medical coupons Medicare Medicaid Employer or Private Insurance Other _____		
Person assisting applicant with this application (if any) Name Phone		
If referred by an organization, provide the Organization Name, Phone Number and Contact Person		
List services needing help with: Eye Exam / Eye Glasses - Low Vision Aid - Other		
Why I need help with these services?		
Signature of Applicant Date		

Signature of Applicant confirms this is a true and accurate statement of their personal current circumstances.

COMPLETE ALL SECTIONS ON THE REVERSE SIDE

COMPLETE ALL BLANKS

MONTHLY INCOME FOR ENTIRE HOUSEHOLD

"Take Home" pay from Employment for the entire household	$
Social Security Benefits (total for all family members)	$
Child Support (actual amount you receive each month)	$
Retirement Benefits	$
Veteran's Benefits	$
Public Assistance (AFDC, GAU, SSI, Food Stamps)	$
Unemployment Benefits (weekly x 4 + ?)	$
Other Income (specify)	$
TOTAL MONTHLY INCOME	**$**

If you have little or no income, fully explain how you are able to support yourself; for example, who you are living with and who is supporting you. Use a separate sheet of paper if necessary.

_____

PERSONAL ASSETS **List Value**

Vehicle #1	Year	Make	Plate #	State	$
Vehicle #2	Year	Make	Plate #	State	$
Value of Boat, RV or Other Recreational Equipment	Year	Make	Plate #	State	$
Savings Account(s)					$
Checking Account(s)					$
Stocks, Bonds, CD's, etc					$
Value of Home and other Real Estate					$
Anything else of value					$
TOTAL VALUE OF ASSETS					**$**

MONTHLY EXPENSES

Housing (Circle One) Rent or Mortgage Payment	$
Food	$
Utilities: Electric	$
Water	$
Telephone	$
Cell phone	$
Vehicle Fuel	$
Car Payment(s) (specify vehicle and amount each)	$
Insurance Cost	$
Medical Bills	$
Dental Bills	$
Medical/Dental Insurance	$
Loan Repayment (specify)	$
Credit Card Payments	$
Other Monthly Expenses (specify)	$
TOTAL MONTHLY EXPENSES	**$**

THIS SECTION FOR USE OF LIONS SIGHT FOUNDATION COMMITTEE Form # LSFCC 11/3/09

APPROVED DOCTOR _____ VOUCHER # _____

DENIED REASON _____

LSFCC AUTHORIZING SIGNATURE _____ DATE _____